907 KAR 1:026. Dental services' coverage provisions and requirements.

RELATES TO: KRS 205.520, 205.8451, 42 U.S.C. 1396a-d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a-d

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has the responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Kentucky Medicaid Program provisions and requirements regarding the coverage of dental services.

Section 1. Definitions. (1) "Comprehensive orthodontic" means a medically necessary dental service for treatment of a dentofacial malocclusion which requires the application of braces for correction.

(2) "Current Dental Terminology" or "CDT" means a publication by the American Dental Association of codes used to report dental procedures or services.

(3) "Debridement" means a preliminary procedure that:

(a) Entails the gross removal of plaque and calculus that interfere with the ability of a dentist to perform a comprehensive oral evaluation;

(b) Does not preclude the need for further procedures; and

(c) Is separate from a regular cleaning and is usually a preliminary or first treatment when an individual has developed very heavy plaque or calculus.

(4) "Department" means the Department for Medicaid Services or its designee.

(5) "Direct practitioner contact" means the billing dentist or oral surgeon is physically present with and evaluates, examines, treats, or diagnoses the recipient.

(6) "Disabling malocclusion" means a condition that meets the criteria established in Section 13(7) of this administrative regulation.

(7) "Electronic signature" is defined by KRS 369.102(8).

(8) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(9) "Incidental" means that a medical procedure:

(a) Is performed at the same time as a primary procedure; and

(b)1. Requires little additional practitioner resources; or

2. Is clinically integral to the performance of the primary procedure.

(10) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(11) "Locum tenens dentist" means a substitute dentist:

(a) Who temporarily assumes responsibility for the professional practice of a dentist participating in the Kentucky Medicaid Program; and

(b) Whose services are paid under the participating dentist's provider number.

(12) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined by 42 C.F.R. 438.2.

(13) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(14) "Mutually exclusive" means that two (2) procedures:

(a) Are not reasonably performed in conjunction with one (1) another during the same patient encounter on the same date of service;

(b) Represent two (2) methods of performing the same procedure;

(c) Represent medically impossible or improbable use of CDT codes; or

(d) Are described in CDT as inappropriate coding of procedure combinations.

(15) "Other licensed medical professional" or "OLMP" means a health care provider other than a dentist who has been approved to practice a medical specialty by the appropriate licensure board.

(16) "Prepayment review" or "PPR" means a departmental review of a claim regarding a recipient who is not enrolled with a managed care organization to determine if the requirements of this administrative regulation have been met prior to authorizing payment.

(17) "Prior authorization" or "PA" means approval that a provider shall obtain from the department before being reimbursed for a covered service.

(18) "Provider" is defined by KRS 205.8451(7).

(19) "Public health hygienist" means an individual who:

(a) Is a dental hygienist as defined by KRS 313.010(6);

(b) Meets the public health hygienist requirements established in KRS 313.040(8);

(c) Meets the requirements for a public health registered dental hygienist established in 201 KAR 8:562; and

(d) Is employed by or through:

1. The Department for Public Health; or

2. A governing board of health.

(20) "Recipient" is defined by KRS 205.8451(9).

(21) "Resident" is defined by 42 C.F.R. 415.152.

(22) "Timely filing" means receipt of a claim by Medicaid:

(a) Within twelve (12) months of the date the service was provided;

(b) Within twelve (12) months of the date retroactive eligibility was established; or

(c) Within six (6) months of the Medicare adjudication date if the service was billed to Medicare.

Section 2. Conditions of Participation. (1) A participating provider shall:

(a) Be licensed as a provider in the state in which the practice is located;

(b) Comply with the terms and conditions established in the following administrative regulations:

1. 907 KAR 1:005;

2. 907 KAR 1:671; and

3. 907 KAR 1:672;

(c) Comply with the requirements to maintain the confidentiality of personal medical records pursuant to 42 U.S.C. 1320d and 45 C.F.R. Parts 160 and 164; and

(d) Comply with all applicable state and federal laws.

(2)(a) A participating provider shall:

1. Have the freedom to choose whether to accept an eligible Medicaid recipient; and

2. Notify the recipient of the decision prior to the delivery of service.

(b) If the provider accepts the recipient, the provider:

1. Shall bill Medicaid rather than the recipient for a covered service;

2. May bill the recipient for a service not covered by Kentucky Medicaid, if the provider informed the recipient of noncoverage prior to providing the service; and

3. Shall not bill the recipient for a service that is denied by the department for:

a. Being:

(i) Incidental;

(ii) Integral; or

(iii) Mutually exclusive;

b. Incorrect billing procedures, including incorrect bundling of procedures;

c. Failure to obtain prior authorization for the service; or

d. Failure to meet timely filing requirements.

(3)(a) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(b) A provider of a service to an enrollee shall be enrolled in the Medicaid Program.

(4)(a) If a provider receives any duplicate or overpayment from the department or managed care organization, regardless of reason, the provider shall return the payment to the department or managed care organization.

(b) Failure to return a payment to the department or managed care organization in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

Section 3. Record Maintenance. (1)(a) A provider shall maintain comprehensive legible medical records that substantiate the services billed.

(b) A dental record shall be considered a medical record.

(2) A medical record shall be signed on the date of service by the:

(a) Provider; or

(b) Other practitioner authorized to provide the service in accordance with:

1. KRS 313.040; and

2. 201 KAR 8:562.

(3) An X-ray shall be:

(a) Of diagnostic quality; and

(b) Maintained in a manner that identifies the:

1. Recipient's name;

2. Service date; and

3. Provider's name.

(4) A treatment regimen shall be documented to include:

(a) Diagnosis;

(b) Treatment plan;

(c) Treatment and follow-up; and

(d) Medical necessity.

(5) Medical records, including X-rays, shall be maintained in accordance with 907 KAR 1:672.

Section 4. General and Certain Service Coverage Requirements. (1) A covered service shall be:

(a) Medically necessary; and

(b) Except as provided in subsection (3) of this section, furnished to a recipient through direct practitioner contact.

(2) Dental visits shall be limited to twelve (12) visits per year per provider for a recipient who is at least twenty-one (21) years of age.

(3) A covered service provided by an other licensed medical professional shall be covered if the:

(a) OLMP is employed by the supervising oral surgeon, dentist, or dental group;

(b) OLMP is licensed in the state of practice; and

(c) Supervising provider has direct practitioner contact with the recipient, except for a service provided by a dental hygienist if the dental hygienist provides the service under general

supervision of a practitioner in accordance with KRS 313.040.

(4)(a) A medical resident may provide and the department shall cover services if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.170, 415.172, and 415.174.

(b) A dental resident, student, or dental hygiene student may provide and the department shall cover services under the direction or supervision of a program participating provider in or affiliated with an American Dental Association accredited institution.

(5) Services provided by a locum tenens dentist shall be covered:

(a) If the locum tenens dentist:

1. Has a national provider identifier (NPI) and provides the NPI to the department;

2. Does not have a pending criminal or civil investigation regarding the provision of services;

3. Is not subject to a formal disciplinary sanction from the Kentucky Board of Dentistry; and

4. Is not subject to any federal or state sanction or penalty that would bar the dentist from Medicare or Medicaid participation; and

(b) For no more than sixty (60) continuous days.

(6) Preventative services provided by a public health hygienist shall be covered.

(7) The department shall cover the oral pathology procedures listed on the DMS Dental Fee Schedule if provided by an oral pathologist who meets the condition of participation requirements established in Section 2 of this administrative regulation.

(8) Coverage shall be limited to the procedures or services:

(a) Identified on the DMS Dental Fee Schedule; or

(b) Established in this administrative regulation.

(9) The department shall not cover a service provided by a provider or practitioner that exceeds the scope of services established for the provider or practitioner in:

(a) Kentucky Revised Statutes; or

(b) Kentucky administrative regulations.

Section 5. Diagnostic Service Coverage Limitations. (1)(a) Except as provided in paragraph (b) of this subsection, coverage for a comprehensive oral evaluation shall be limited to one (1) per twelve (12) month period, per recipient, per provider.

(b) The department shall cover a second comprehensive oral evaluation if the evaluation is provided in conjunction with a prophylaxis to an individual under twenty-one (21) years of age.

(c) A comprehensive oral evaluation shall not be covered in conjunction with the following:

1. A limited oral evaluation for trauma related injuries;

2. A space maintainer;

3. Denture relining;

4. A transitional appliance;

5. A prosthodontic service;

6. Temporomandibular joint therapy;

7. An orthodontic service;

8. Palliative treatment;

9. An extended care facility call;

10. A house call; or

11. A hospital call.

(2)(a) Coverage for a limited oral evaluation shall:

1. Be limited to a trauma related injury or acute infection; and

2. Be limited to one (1) per date of service, per recipient, per provider.

(b) A limited oral evaluation shall not be covered in conjunction with another service except for:

1. A periapical X-ray;

2. A bitewing X-ray;
3. A panoramic X-ray;
4. Resin, anterior;
5. A simple or surgical extraction;
6. Surgical removal of a residual tooth root;
7. Removal of a foreign body;
8. Suture of a recent small wound;
9. Intravenous sedation; or
10. Incision and drainage of infection.

(3)(a) Except as provided in paragraph (b) of this subsection, the following limitations shall apply to coverage of a radiograph service:

1. Bitewing X-rays shall be limited to four (4) per twelve (12) month period, per recipient, per provider;

2. Periapical X-rays shall be limited to fourteen (14) per twelve (12) month period, per recipient, per provider;

3. An intraoral complete X-ray series shall be limited to one (1) per twenty-four (24) month period, per recipient, per provider;

4. Periapical and bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider;

5. A panoramic film shall:

a. Be limited to one (1) per twenty-four (24) month period, per recipient, per provider; and

b. Require prior authorization in accordance with Section 15(1), (2), and (3) of this administrative regulation for a recipient under the age of six (6) years;

6. A cephalometric film shall be limited to one (1) per twenty-four (24) month period, per recipient, per provider; or

7. A cephalometric and panoramic X-ray shall not be covered separately in conjunction with a comprehensive orthodontic consultation.

(b) The limits established in paragraph (a) of this subsection shall not apply to:

1. An X-ray necessary for a root canal or oral surgical procedure; or

2. An X-ray that:

a. Exceeds the established service limitations; and

b. Is determined by the department to be medically necessary.

Section 6. Preventive Service Coverage Limitations. (1)(a) Coverage of a prophylaxis shall be limited to:

1. For an individual who is at least twenty-one (21) years of age, one (1) per twelve (12) month period, per recipient; and

2. For an individual under twenty-one (21) years of age, one (1) per six (6) month period, per recipient.

(b) A prophylaxis shall not be covered in conjunction with periodontal scaling or root planing.

(2)(a) Coverage of a sealant shall be limited to:

1. A recipient of the age five (5) through twenty (20) years;

2. Each six (6) and twelve (12) year molar once every four (4) years with a lifetime limit of three (3) sealants per tooth, per recipient; and

3. An occlusal surface that is noncavitated.

(b) A sealant shall not be covered in conjunction with a restorative procedure for the same tooth on the same surface on the same date of service.

(3)(a) Coverage of a space maintainer shall:

1. Be limited to a recipient under the age of twenty-one (21) years; and

2. Require the following:

a. Fabrication;
b. Insertion;
c. Follow-up visits;
d. Adjustments; and
e. Documentation in the recipient's medical record to:
(i) Substantiate the use for maintenance of existing interdental space; and
(ii) Support the diagnosis and a plan of treatment that includes follow-up visits.

(b) The date of service for a space maintainer shall be considered to be the date the appliance is placed on the recipient.

(c) Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per recipient.

Section 7. Restorative Service Coverage Limitations. (1) A four (4) or more surface resin-based anterior composite procedure shall not be covered if performed for the purpose of cosmetic bonding or veneering.

(2) Coverage of a prefabricated crown shall:
(a) Be limited to a recipient under the age of twenty-one (21) years; and
(b) Include any procedure performed for restoration of the same tooth.

(3) Coverage of a pin retention procedure shall be limited to:
(a) A permanent molar;
(b) One (1) per tooth, per date of service, per recipient; and
(c) Two (2) per permanent molar, per recipient.

(4) Coverage of a restorative procedure performed in conjunction with a pin retention procedure shall be limited to one (1) of the following:
(a) An appropriate medically necessary restorative material encompassing three (3) or more surfaces;
(b) A permanent prefabricated resin crown; or
(c) A prefabricated stainless steel crown.

Section 8. Endodontic Service Coverage Limitations. (1) Coverage of the following endodontic procedures shall be limited to a recipient under the age of twenty-one (21) years:
(a) A pulp cap direct;
(b) Therapeutic pulpotomy; or
(c) Root canal therapy.

(2) A therapeutic pulpotomy shall not be covered if performed in conjunction with root canal therapy.

(3)(a) Coverage of root canal therapy shall require:
1. Treatment of the entire tooth;
2. Completion of the therapy; and
3. An x-ray taken before and after completion of the therapy.

(b) The following root canal therapy shall not be covered:
1. The Sargenti method of root canal treatment; or
2. A root canal that does not treat all root canals on a multi-rooted tooth.

Section 9. Periodontic Service Coverage Limitations. (1) Coverage of a gingivectomy or gingivoplasty procedure shall require prepayment review and shall be limited to:
(a) A recipient with gingival overgrowth due to a:
1. Congenital condition;
2. Hereditary condition; or

3. Drug-induced condition; and

(b) One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period.

1. Coverage of a quadrant procedure shall require a minimum of a four (4) tooth area within the same quadrant.

2. Coverage of a per-tooth procedure shall be limited to no more than three (3) teeth within the same quadrant.

(2) Coverage of a gingivectomy or gingivoplasty procedure shall require documentation in the recipient's medical record that includes:

(a) Pocket-depth measurements;

(b) A history of nonsurgical services; and

(c) A prognosis.

(3) Coverage for a periodontal scaling and root planing procedure shall:

(a) Not exceed one (1) per quadrant, per twelve (12) months, per recipient, per provider;

(b) Require prior authorization in accordance with Section 15(1), (2), and (4) of this administrative regulation; and

(c) Require documentation to include:

1. A periapical film or bitewing X-ray;

2. Periodontal charting of preoperative pocket depths; and

3. A photograph if applicable.

(4)(a) Coverage of a quadrant procedure shall require a minimum of a four (4) tooth area within the same quadrant.

(b) Coverage of a per-tooth procedure shall be limited to no more than three (3) teeth.

(5) Periodontal scaling and root planing shall not be covered if performed in conjunction with dental prophylaxis.

(6)(a) A full mouth debridement shall only be covered for a pregnant woman.

(b) More than one (1) full mouth debridement per pregnancy shall not be covered.

Section 10. Prosthodontic Service Coverage Limitations. (1) A removable prosthodontic or denture repair shall be limited to a recipient under the age of twenty-one (21) years.

(2) A denture repair in the following categories shall not exceed three (3) repairs per twelve (12) month period, per recipient:

(a) Repair resin denture base; or

(b) Repair cast framework.

(3) Coverage for the following services shall not exceed one (1) per twelve (12) month period, per recipient:

(a) Replacement of a broken tooth on a denture;

(b) Laboratory relining of:

1. Maxillary dentures; or

2. Mandibular dentures;

(c) An interim maxillary partial denture; or

(d) An interim mandibular partial denture.

(4) An interim maxillary or mandibular partial denture shall be limited to use:

(a) During a transition period from a primary dentition to a permanent dentition;

(b) For space maintenance or space management; or

(c) As interceptive or preventive orthodontics.

Section 11. Maxillofacial Prosthetic Service Coverage Limitations. The following services shall be covered if provided by a board eligible or board certified-prosthodontist:

(1) A nasal prosthesis;

(2) An auricular prosthesis;
(3) A facial prosthesis;
(4) A mandibular resection prosthesis;
(5) A pediatric speech aid;
(6) An adult speech aid;
(7) A palatal augmentation prosthesis;
(8) A palatal lift prosthesis;
(9) An oral surgical splint; or
(10) An unspecified maxillofacial prosthetic.

Section 12. Oral and Maxillofacial Service Coverage Limitations. (1) The simple use of a dental elevator shall not constitute a surgical extraction.

(2) Root removal shall not be covered on the same date of service as the extraction of the same tooth.

(3) Coverage of surgical access of an unerupted tooth shall:
(a) Be limited to exposure of the tooth for orthodontic treatment; and
(b) Require prepayment review.

(4) Coverage of alveoplasty shall:
(a) Be limited to one (1) per quadrant, per lifetime, per recipient; and
(b) Require a minimum of a four (4) tooth area within the same quadrant.

(5) An occlusal orthotic device shall:
(a) Be covered for temporomandibular joint therapy;
(b) Require prior authorization in accordance with Section 15(1), (2), and (5) of this administrative regulation;
(c) Be limited to a recipient under the age of twenty-one (21) years; and
(d) Be limited to one (1) per lifetime, per recipient.

(6) Frenulectomy shall be limited to two (2) per date of service.

(7) Coverage shall be limited to one (1) per lifetime, per recipient, for removal of the following:
(a) Torus palatinus (maxillary arch);
(b) Torus mandibularis (lower left quadrant); or
(c) Torus mandibularis (lower right quadrant).

Section 13. Orthodontic Service Coverage Limitations. (1) Coverage of an orthodontic service shall:
(a) Be limited to a recipient under the age of twenty-one (21) years; and
(b) Require prior authorization except as established in Section 15(1)(b) of this administrative regulation.

(2) The combination of space maintainers and appliance therapy shall be limited to two (2) per twelve (12) month period, per recipient.

(3) Space maintainers and appliance therapy shall not be covered in conjunction with comprehensive orthodontics.

(4) The department shall only cover new orthodontic brackets or appliances.

(5) An appliance for minor tooth guidance shall not be covered for the control of harmful habits.

(6) In addition to the limitations specified in subsection (1) of this section, a comprehensive orthodontic service shall:
(a) Require a referral by a dentist; and
(b) Be limited to the correction of a disabling malocclusion for transitional, full permanent dentition, or treatment of a cleft palate or severe facial anomaly.

(7) A disabling malocclusion shall:

(a) Exist if a patient:

1. Exhibits a severe overbite encompassing one (1) or more teeth in palatal impingement diagnosed by a lingual view of orthodontic models (stone or digital) showing palatal soft tissue contact;

2. Exhibits a true anterior open bite:

a. Either skeletal or habitual in nature that if left untreated will result in:

(i) The open bite persisting; or

(ii) A medically documented speech impediment; and

b. That does not include:

(i) One (1) or two (2) teeth slightly out of occlusion; or

(ii) Where the incisors have not fully erupted;

3. Demonstrates a significant antero-posterior discrepancy (Class II or III malocclusion that is comparable to at least one (1) full tooth Class II or III):

a. Dental or skeletal; and

b. If skeletal, requires a traced cephalometric radiograph supporting significant skeletal malocclusion;

4. Has an anterior crossbite that involves:

a. More than two (2) teeth within the same arch; or

b. A single tooth crossbite if there is evident detrimental changes in supporting tissues including:

(i) Obvious gingival stripping; or

(ii) A functional shift of the mandible or severe dental attrition for an individual under the age of twelve (12) years; or

c. An edge to edge crossbite if there is severe dental attrition due to a traumatic occlusion;

5. Demonstrates a handicapping posterior transverse discrepancy that:

a. May include several teeth, one (1) of which shall be a molar; and

b. Is handicapping in a function fashion as follows:

(i) Functional shift;

(ii) Facial asymmetry; or

(iii) A complete buccal or lingual crossbite;

6. Demonstrates a medically documented speech pathology resulting from the malocclusion;

7. Demonstrates a significant posterior open bite that does not involve:

a. Partially erupted teeth; or

b. One (1) or two (2) teeth slightly out of occlusion;

8. Except for third molars, demonstrates an impacted tooth that:

a. Will not erupt into the arch without orthodontic or surgical intervention; and

b.(i) Shows a documented pathology; or

(ii) Poses a significant threat to the integrity of the remaining dentition or to the health of the patient;

9. Has an extreme overjet in excess of eight (8) millimeters and one (1) of the skeletal conditions specified in subparagraphs 1 through 8 of this paragraph;

10. Has trauma or injury resulting in severe misalignment of the teeth or alveolar structures and does not include simple loss of teeth with no other affects;

11. Has a congenital or developmental disorder giving rise to a handicapping malocclusion;

12. Has a significant facial discrepancy requiring a combined orthodontic and orthognathic surgery treatment approach; or

13. Has developmental anodontia in which several congenitally missing teeth result in a handicapping malocclusion or arch deformation; and

(b) Not include:

1. One (1) or two (2) teeth being slightly out of occlusion;
2. Incisors not having fully erupted; or
3. A bimaxillary protrusion.

(8) Coverage of comprehensive orthodontic treatment shall not include orthognathic surgery.

(9) If comprehensive orthodontic treatment is discontinued prior to completion, the provider shall submit to the department:

(a) Documentation of the referral referenced in subsection (6) of this section; and

(b) A letter detailing:

1. Treatment provided, including dates of service;
2. Current treatment status of the patient; and
3. Charges for the treatment provided.

(10) Remaining portions of comprehensive orthodontic treatment may be authorized for prorated coverage upon compliance with the prior authorization requirements specified in Section 15(1), (2), and (7) of this administrative regulation if treatment:

(a) Is transferred to another provider; or

(b) Began prior to Medicaid eligibility.

Section 14. Adjunctive General Service Coverage Limitations. (1)(a) Coverage of palliative treatment for dental pain shall be limited to one (1) per date of service, per recipient, per provider.

(b) Palliative treatment for dental pain shall not be covered in conjunction with another service except for a radiograph.

(2) Coverage of a hospital or ambulatory surgical center call or extended care facility call shall be limited to one (1) per date of service, per recipient, per provider.

(b) A hospital call, ambulatory surgical center call, or extended care facility call shall not be covered in conjunction with:

1. Limited oral evaluation;
2. Comprehensive oral evaluation; or
3. Treatment of dental pain.

(3) Intravenous sedation shall not be covered for local anesthesia or nitrous oxide.

Section 15. Prior Authorization. (1)(a) The prior authorization requirements established in this administrative regulation shall apply to services for a recipient who is not enrolled with a managed care organization.

(b) A managed care organization shall not be required to apply the prior authorization requirements established in this administrative regulation for a recipient who is enrolled with the managed care organization.

(c) Prior authorization shall be required for the following:

1. A panoramic film for a recipient under the age of six (6) years;
2. Periodontal scaling and root planing;
3. An occlusal orthotic device;
4. A preorthodontic treatment visit;
5. Removable appliance therapy;
6. Fixed appliance therapy; or
7. A comprehensive orthodontic service.

(2) A provider shall request prior authorization by submitting the following information to the department:

(a) A MAP-9, Prior Authorization for Health Services;

(b) Additional forms or information as specified in subsections (3) through (8) of this section; and

(c) Additional information required to establish medical necessity if requested by the department.

(3) A request for prior authorization of a panoramic film shall include a letter of medical necessity.

(4) A request for prior authorization of periodontal scaling and root planing shall include periodontal charting of preoperative pocket depths.

(5) A request for prior authorization of an occlusal orthotic device shall include a MAP 306, Temporomandibular Joint (TMJ) Assessment Form.

(6) A request for prior authorization of removable and fixed appliance therapy shall include:

(a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;

(b) Panoramic film or intraoral complete series; and

(c) Dental models or the digital equivalent of dental models.

(7) A request for prior authorization for comprehensive orthodontic services shall include:

(a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;

(b) A MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement;

(c) A cephalometric X-ray with tracing;

(d) A panoramic X-ray;

(e) Intraoral and extraoral facial frontal and profile pictures;

(f) An occluded and trimmed dental model or the digital equivalent of a model; and

(g) An oral surgeon's pretreatment work up notes if orthognathic surgery is required.

(8) If prior authorization for comprehensive orthodontic services is given following a request submitted pursuant to subsection (7) of this section, additional information shall be submitted as required in this subsection.

(a) After six (6) monthly visits are completed, but not later than twelve (12) months after the banding date of service, the provider shall submit:

1. A MAP 559, Six (6) Month Orthodontic Progress Report; and

2. An additional MAP 9, Prior Authorization for Health Services.

(b) Within three (3) months following completion of the comprehensive orthodontic treatment, the provider shall submit:

1. Beginning and final records; and

2. A MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission.

(9) Upon receipt and review of the materials required in subsection (7)(a) through (g) of this section, the department may request a second opinion from another provider regarding the proposed comprehensive orthodontic treatment.

(10) If a service that requires prior authorization is provided before the prior authorization is received, the provider shall assume the financial risk that the prior authorization may not be subsequently approved.

(11)(a) Prior authorization shall not be a guarantee of recipient eligibility.

(b) Eligibility verification shall be the responsibility of the provider.

(12) Upon review and determination by the department that removing a prior authorization requirement shall be in the best interest of a Medicaid recipient, the prior authorization requirement for a specific covered benefit shall be discontinued, at which time the covered benefit shall be available to all recipients without prior authorization.

Section 16. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A dental service provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature.

Section 17. Auditing Authority. (1) The department or the managed care organization in which an enrollee is enrolled shall have the authority to audit any:

(a) Claim;

(b) Medical record; or

(c) Documentation associated with any claim or medical record.

(2) A dental record shall be considered a medical record.

Section 18. Federal Approval and Federal Financial Participation. The coverage provisions and requirements established in this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval of the coverage.

Section 19. Appeal Rights. An appeal of a department decision regarding a Medicaid recipient who is:

(1) Enrolled with a managed care organization shall be in accordance with 907 KAR 17:010; or

(2) Not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

Section 20. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "MAP 9, Prior Authorization for Health Services", December 1995;

(b) "MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement", December 1995;

(c) "MAP 306, Temporomandibular Joint (TMJ) Assessment Form", December 1995;

(d) "MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form", March 2001;

(e) "MAP 559, Six (6) Month Orthodontic Progress Report", December 1995;

(f) "MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission", December 1995; and

(g) "DMS Dental Fee Schedule", December 2015.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law:

(a) At the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.; or

(b) Online at the department's Web site located at http://www.chfs.ky.gov/dms/incorporated.htm. (2 Ky.R. 106; eff. 9-10-1975; 5 Ky.R. 63; eff. 9-6-1978; 6 Ky.R. 92; eff. 9-5-1979; 8 Ky.R. 531; eff. 2-1-1982; 9 Ky.R. 503; eff. 11-3-1982; 980; eff. 3-2-1983; 12 Ky.R. 1081; eff. 1-3-1986; Recodified from 904 KAR 1:026, 5-2-1986; Am. 14

Ky.R. 663; eff. 11-6-1987; 16 Ky.R. 267; eff. 9-20-1989; 21 Ky.R. 139; 930; eff. 8-17-1994; 23 Ky.R. 3450; 3782; eff. 4-16-1997; 25 Ky.R. 654; 1379; eff. 11-18-1998; 30 Ky.R. 1630; 1939; eff. 2-16-2004; 33 Ky.R. 582; 1371; 1552; eff. 1-5-2007; 35 Ky.R. 436; 841; eff. 10-31-2008; 42 Ky.R. 148; 1226; 2144; eff. 2-5-2016.)